



State Health Watch

Vol. 16 No. 10

The Newsletter on State Health Care Reform

October 2009



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For long-term care, shift to community-based services gains momentum

Some experts suggest that there is no question that programs transitioning nursing home patients to community-based services save money and are better for patients. For most Medicaid programs, community services are limited and waiting lists are long, but a growing number are doing something about this long-standing problem.

To date, 30 state Medicaid programs have received grants from the Money Follows the Person Demonstration (MFP), a Medicaid initiative enacted into law in 2006. States receive enhanced federal support for Medicaid long-term care programs by providing more services in the

community and fewer in institutional settings.

"While the 'Is home and community-based service cost-effective?' question is 25 years old, there is no disagreement that the nursing home transition programs are cost-effective," says Leslie Hendrickson, PhD, principal of East Windsor, NJ-based Hendrickson Development, a consulting firm that provides information to develop and strengthen long-term care programs for Medicaid and other state-funded programs.

The MFP program is based on

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Florida restores planned cuts to its Medically Needy program

Florida Medicaid is expected to receive about \$5 billion from The American Recovery and Reinvestment Act of 2009 (ARRA) during the 27-month period for which the stimulus package is in effect.

**Fiscal Fitness:
How States Cope**

"This increase in federal funding will free up state money that would have been needed to fund the Medicaid program. This may now be used by the legislature to fund other areas of the state budget," says Medicaid director Carlton D. Snipes.

In order to receive the enhanced federal medical assistance percentage (FMAP), states must maintain the program eligibility standards that were in place as of July 1, 2008. Therefore, for Florida, continued funding of services to adults under the Medically Needy program and restoration of its Medicaid for the Aged and Disabled Program (Meds AD program) beyond July 1, 2009, was required.

Prior to the 2009 legislative session the Meds AD coverage was scheduled to expire July 1, 2009,

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State Health Watch (ISSN# 1074-4754) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to *State Health Watch*, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information:
Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m. - 6 p.m. Monday-Thursday; 8:30 a.m. - 4:30 p.m. Friday ET.
E-mail: customerservice@ahcmedia.com.
Web site: www.ahcmedia.com.

Subscription rates: \$399 per year. Add \$17.95 for shipping & handling. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Back issues, when available, are \$67 each.

Government subscription rates: Call customer service at (800) 688-2421 for current rate. For information on multiple subscription rates, call Steve Vance at (404) 262-5511.

(GST registration number R128870672.)

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Long-term care

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the premise that many Medicaid beneficiaries currently residing in institutions *want* to live in the community and could do so if they had adequate support—and at less cost to Medicaid than is currently spent for institutional care.

“While the number of MFP transitions to date has been modest, it is still a clear achievement that the program has already enabled hundreds of people who had been living in a nursing home to return to the community,” says **Molly O’Malley**, a senior policy analyst with the Henry J. Kaiser Family Foundation in Menlo Park, CA. “Going forward, we expect states to continue to transition more people back to the community. This program fits into the broader context of state efforts to promote greater access to Medicaid home and community-based services.”

Challenges are many

In a June 2009 report from the Kaiser Commission on Medicaid and the Uninsured, “Money Follows the Person: An Early Implementation Snapshot,” states reported their biggest challenges were gaining approval from the Centers for Medicare & Medicaid Services (CMS) for their operational protocol and identifying appropriate housing for individuals transitioning back to the community.

“They also reported challenges working with numerous internal and external stakeholders to coordinate transitions,” says Ms. O’Malley. This was a necessary step in the process, though, in order to form collaborative partnerships with stakeholders.

“A program such as MFP is needed. Medicaid programs are not

structured as well as they might be for supporting transitions from institutional care to the community,” says **Carol Irvin**, PhD, a senior researcher at Mathematica Policy Research in Princeton, NJ. “Several factors pose challenges to transitioning institutionalized people to the community.” Ms. Irvin says that some of these challenges include:

—One-time supports that are not long-term care in nature but are critical to help transition someone into a home or community setting may not always be reliably available. This is because a state’s Medicaid program or other social programs often do not adequately cover these services. These include rental or utility deposits, basic furnishings, vehicle modification, and other help with transportation or housing.

—Existing home- and community-based waiver programs are frequently capped. Some programs have long waiting lists that deny some beneficiaries timely access to necessary home and community-based services.

—The range of long-term care services covered by a state’s optional benefit or waiver program is often limited.

—Regulations typically restrict the hours of care per week that a Medicaid beneficiary can receive. It may not be enough for the beneficiary, especially when first transitioning from an institution to the community.

—Housing options are frequently limited, particularly if a beneficiary’s home was sold after entering the institution or modifications are needed to make available housing accessible. “The housing piece seems to be the most common challenge,” says Dr. Irvin.

“At this point in time, all states with MFP grants have established

their programs and have started to transition a wide variety of people from institutional to community care,” says Dr. Irvin. “Several have been transitioning individuals for more than a year. Others are just now starting their transition programs.”

According to Kaiser’s June 2009 report, 11 states reported that they had completed 349 transitions, and 13 states reported that 465 transitions were in progress.

When Dr. Hendrickson contacted all the state MFP programs in early 2009, he found that most don’t use systematic methods to select residents. Methods vary, with some programs relying on referrals from agency staff and others planning on contacting all nursing home residents periodically. For example, Maryland plans to contact all residents every six months. According to data from Mathematica Policy Research, most programs target less than 1% of MFP eligibles.

As for the recession’s impact on these programs, Dr. Hendrickson says, “Whether states are doing this well, or not doing it at all, has nothing to do with the recent economic downturn. It is really more to do with the policy that states use with their long-term care programs.”

When Dr. Hendrickson was responsible for Medicaid long-term care programs as Assistant Commissioner in the New Jersey Department of Health and Social Services, he worked on New Jersey’s transition program, Community Choice. The statewide program, implemented in 1998, provided nursing home residents with information about home and community-based services and housing alternatives and assistance to those who wanted to move out of a nursing home.

More than 3,400 people left

nursing homes with the help of Community Choice counseling between state fiscal years 1998 and 2001, and the state’s total nursing home population declined by 5% during this period. Despite this success, however, the program was not continued. “After we left, the program lapsed for two years, since the policy-makers that followed us were not interested in transition,” says Dr. Hendrickson. “In contrast, Pennsylvania has had a well-operating transition program that has continuously expanded since 2001.”

In Kaiser’s June 2009 report, nearly all states reported *not* having to make budget cuts or changes to MFP programs as a result of the downturn. Ms. Irvin says, however, that some MFP programs *have* been affected by state hiring freezes and furloughs. These have slowed down some of their implementation plans. “Several states have been thinking about scaling back the number of people they will transition as a result,” says Dr. Irvin. “But several have expanded their transition goals.”

Greatest long-term challenge

An independent analysis found that Wisconsin’s Family Care program saved an average of \$452 per person, per month in total medical assistance expenditures. “The program offers people a choice about long-term care. It’s helping seniors and people with disabilities live in dignity by giving them the choice to stay in their own home,” says **Stephanie Marquis**, spokeswoman for the Department of Health Services in Madison, WI.

Ohio has two complementary initiatives that expand community living options for consumers in institutional settings—HOME Choice (Helping Ohioans Move-Expanding Choice) and the Unified Long-Term Care Budget (ULTCB).

HOME Choice is a transition program created through an MFP grant that Ohio was awarded in January 2007. The Ohio Department of Jobs and Family Services administers HOME Choice, which will relocate up to 2,200 people residing in nursing facilities and intermediate care facilities for mental retardation to community care. “The project must also meet CMS-approved targets that begin to shift spending on institutional and community care options into balance,” according to **Erika Robbins**, Ohio’s MFP Project Director. “As demand for community care is expanded through the ULTCB, nursing facilities spending is expected to flatten or decrease, thus freeing up revenue for expansion of additional community care options.”

According to **Jerry Fuller**, Alaska’s Medicaid director, the cost of long-term care is “always a challenge.” Unlike many states, Alaska did not permit a huge growth in nursing home beds, and has been focused on community care for many years.

“We are not facing a big challenge now of transitioning from nursing homes and reducing beds, but rather providing sufficient quality community care for our rapidly growing senior and disabled population that becomes eligible for Medicaid,” says Mr. Fuller.

According to a February 2006 report from the Lewin Group in Falls Church, VA, on Medicaid spending for the state of Alaska, “Long-Term Forecast of Medicaid Enrollment and Spending, 2005-2025,” estimated Medicaid costs will more than quadruple over 25 years. About half of the increase was attributed to the growing need for long-term care services.

“Pacific Health Policy Group did a study and report for our legislature in 2006 that emphasized this issue,” says Mr. Fuller. In addition, a 2008

report by Baltimore-based HCBS Strategies provided an in-depth review of Alaska's current programs to improve their long-term care system. "They made many very good suggestions on how to position the state for the future growth and make the Medicaid program more fiscally sustainable," says Mr. Fuller. The department is in the process of determining what changes to make

and when.

"I believe finding ways to improve community-based services, develop and maintain a work force to provide these services, and implement efficiencies to help make the Medicaid long-term care services more sustainable are the greatest long-term challenges facing the Alaska Medicaid program," says Mr. Fuller.

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Fiscal Fitness

(Continued from cover)

and the broadly defined "medically needy" coverage group was scheduled to expire on June 30, 2009. The statute narrowed the medically needy coverage group definition to cover only pregnant women and children and was scheduled to become effective on July 1, 2009.

The two programs were funded with nonrecurring dollars and would not have carried forward into state fiscal year 2009-2010 without specific legislative action.

During the 2009 Florida Legislative Session, statutory language relating to the MEDS-AD program and the Medically Needy program was amended. Under current statute, both the MEDS-AD coverage and the broadly defined medically needy coverage group are now scheduled to expire Dec. 31, 2010. The statute also narrows the medically needy coverage group definition to cover only pregnant women and children, and this is scheduled to become effective on Jan. 1, 2011. The aged and disabled waiver extends eligibility and full Medicaid coverage to individuals who are disabled or age 65 and older and nondual-eligible, with some exceptions, with incomes at or below 88% of the federal poverty level. The program provides high-intensity pharmacy case management for its enrollees.

"Like all state agencies, we are currently in the process of developing recommendations for the next budget cycle," says Mr. Snipes. Enrollment as of June 30, 2009, was 2,563,906, an increase of 352,847 over the prior year. Despite these challenges, Florida Medicaid has made some efforts to expand services and improve access, such as attracting more dentists to participate in Medicaid. Legislation passed in 2008 changed Florida's licensure requirements to allow dentists licensed in other states to work in health care settings that serve some of Florida's most vulnerable citizens.

In response, Florida Medicaid is updating its policies to allow these out-of-state dentists to serve Medicaid beneficiaries. Also, group practices such as Federally Qualified Community Health Centers and educational institutions now are allowed to enroll as dental providers, so dentists who work at those sites may enroll and bill as treating providers affiliated with the facility.

Additionally, the state's Community-Based Substance Abuse Services Program presents a new opportunity for Florida counties to increase local public funds committed to substance abuse treatment for Medicaid recipients, by receiving federal matching funds for three new Medicaid-funded substance abuse services. "Alcohol and drug intervention services are included in this new Medicaid substance abuse

program," says Mr. Snipes.

Cost-containment elements

Florida Medicaid has many cost-containment elements integrated into the program. These include enrolling beneficiaries in managed care and disease management programs for multiple disease states, incorporating utilization review and prior authorization protocol into program components to ensure appropriate utilization of services, and enforcement of fraud and abuse prevention measures. Here are some examples of these efforts:

- **Managed care.**

Medicaid managed care results in a cost savings, as managed care capitation rates are discounted, on average, 8% from fee-for-service utilization experience. "Managed care also provides coordination and continuity of care that leads to improved access and better health for Medicaid beneficiaries," says Mr. Snipes.

- **Disease management.**

Florida Medicaid disease management programs provide care management services for Medicaid beneficiaries identified as having asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, end-stage renal disease, hemophilia, HIV/AIDS, high blood pressure, sickle cell anemia, chronic fatigue syndrome, fibromyalgia, and chronic back or neck pain.

The disease management programs provide support to the chronically ill with nurse care managers, educational outreach, and coordination of care with providers. According to Mr. Snipes, "The program has demonstrated improved health outcomes and cost-containment by reducing inpatient admissions, length of stay, and reduction in ER visits for the enrolled population."

- **Utilization review.**

"The purpose of the Florida Medicaid Hospital utilization review program is to safeguard against unnecessary and inappropriate medical service rendered to Medicaid beneficiaries," says Mr. Snipes.

The Utilization Management Peer Review Organization performs prior authorization and concurrent review of Medicaid services for hospital, home health, private-duty nursing, and personal care services. This determines three things:

- whether services are reasonable and medically necessary or otherwise allowable under Florida Administrative Code, Hospital Services Coverage, and Limitations Handbook.

- whether the quality of such services meets professionally recognized standards of health care;

- whether the services are adequate, and are consistent with the provision of appropriate medical care, or could be effectively provided more economically at a lower level of care;

Additionally, the agency has

implemented reimbursement and utilization management reforms. These include prior authorization for inpatient psychiatric days, prior authorization for nonemergency hospital inpatient admissions for individuals 21 years of age and older, authorization of emergency and urgent care admissions within 24 hours after admission, enhanced utilization, concurrent review programs for highly utilized services, and reduction or elimination of covered days of service.

- **Prior authorization of medical services.**

Florida Medicaid prior authorizes various services to ensure appropriate utilization, including transplants, adult vision, hearing, dental, orthodontic, and ophthalmology. "Florida Medicaid's Durable Medical Equipment program does require certain equipment to be prior authorized," says Mr. Snipes.

Examples of items that require prior authorization are custom wheelchairs, noncustom motorized wheelchairs, hospital beds, augmentative alternative communication devices, external insulin pumps, and custom cranial remolding devices.

"We review each prior authorization based on our definition of medical necessity, any additional criteria, and if the item is the least costly alternative to meet the beneficiary's medical need," says Mr. Snipes. "As a result, the Durable Medical Equipment program contains costs by approving only the most medically appropriate equipment that

will meet the beneficiary's needs."

- **Medicaid Preferred Drug List.**

The Florida Medicaid Preferred Drug List continues to produce significant savings for pharmacy costs since its implementation as a mandatory program in 2005. The savings are achieved in two ways. First, there is cost avoidance through prior authorization required in prescribing protocols. Second, through the State Supplemental Rebate Program, negotiated cash rebates are received from manufacturers relating to placement on the Preferred Drug List.

"Florida Medicaid receives a net discount through rebates, both required federal rebates and negotiated state supplemental rebate agreements, of approximately 47% on drug costs in the program," says Mr. Snipes.

- **Fraud and abuse prevention.**

Efforts involve all aspects of Medicaid program oversight, including provider enrollment, system edit claims management, policy enhancement, licensure, surveys, prevention methods, early intervention, identification by audit and recoupment of overpayments, sanctions, provider suspensions and terminations, and referrals to other state and federal agencies.

"The Medicaid program works continually to identify and prevent fraudulent and abusive activities," says Mr. Snipes. "Combating Medicaid fraud, abuse, and waste is a significant effort throughout the various divisions of the Agency for Health Care Administration." ■

Florida Medicaid gets HIT boost from federal stimulus

The American Recovery and Reinvestment Act of 2009 (ARRA) provides significant funding to create a national health information network for the exchange of electronic health records. "The bill places a great deal of

responsibility on the states to plan and help create a state electronic health information exchange that will link with the nationwide exchange," says Medicaid director **Carlton D. Snipes**. "Florida's Agency for Health Care Administration has a major role

in implementing various parts of ARRA, most notably having to do with Medicaid and health information technology (HIT)."

The ARRA provides a grant program for states to plan for and help build a health records exchange, a

loan program to help providers purchase the equipment they need to “plug into” the exchange, and another financial assistance program to help Medicaid providers who purchase and use health information technology equipment.

“The impact on Florida is significant. We have identified opportunities to provide additional Medicaid funding for qualified electronic health record implementation to about half of the hospitals in the state, Federally Qualified Health Centers, and the 67 county health departments and their satellite clinics,” says Mr. Snipes.

In addition, certain private high-volume Medicaid providers, such as

pediatricians, can receive funding. “These providers will then be in a position to exchange clinical information through the statewide health information exchange, to be funded through grants to the states,” says Mr. Snipes. The agency also will coordinate with federally funded regional extension centers to support Medicaid outreach and training for the adoption of HIT.

HIN expected to roll out

Another significant and related HIT initiative under way is the Medicaid Health Information Network (HIN), which is expected to roll out this fall. The Medicaid HIN will enable clinicians to access

Medicaid claims data on their patients, showing the medical encounter history of the patient for all providers billing through Medicaid, and any other payer participating in the HIN.

“The information can improve coordination of care by presenting the full spectrum of encounters to clinicians,” says Mr. Snipes. “In addition, the HIN will include a personal health record portal for Medicaid recipients. This will provide tools for self-care such as immunization scheduling, infant growth norms, and tracking lab results. In the second year, Medicaid recipients will have access to their own claims history.” ■

Study says 45,000 Medicaid physicians are eligible for HIT funds

About 45,000 office-based physicians are eligible for up to \$63,750 over six years to improve and maintain their health information technology (HIT) systems, as long as they see at least 30% Medicaid beneficiaries, or 20% for pediatricians, and demonstrate “meaningful use” of HIT, according to a new analysis by researchers at The George Washington University, funded through the Geiger Gibson/RCHN Community Health Foundation Research Collaborative.

The new report, “Boosting Health Information Technology in Medicaid: The Potential Effect of the American Recovery and Reinvestment Act (ARRA)” examines Medicaid HIT adoption incentives in the 2009 law.

This study is the first to explore the potential impact of the Medicaid provisions on physicians’ access to incentive funding. According to **Leighton Ku**, PhD, MPH, one of the report’s authors and a professor in the department of health policy at The George Washington University School of Public Health and Health Services in Washington, DC, state Medicaid

directors need to be aware of these provisions and have to agree to provide the funding incentives to physicians under their state programs.

“The federal rules let states provide this incentive funding and provide full federal funding for these incentives,” says Dr. Ku. “States are not required to cooperate, but I’d expect that all states, or almost all, would agree.”

States will need to distribute guidance information to providers in their states, receive and process applications, and provide funding, although the federal government would reimburse states. A critical requirement is that states assure that the physicians are “meaningful users” of the HIT.

“[The Department of Health and Human Services] has not yet issued rules on what ‘meaningful use,’ constitutes, but states would be obliged to fit in that framework,” says Dr. Ku. Other funds in ARRA may be provided to help states develop HIT infrastructure, such as setting up regional health information organizations or networks.

“These do not need to be done by the Medicaid agencies, but I’d think that Medicaid agencies would want to be intimately involved in these efforts in their states,” says Dr. Ku. “This offers a huge opportunity for Medicaid directors to become focal points and agents for promoting HIT in their states.”

The Medicaid provisions in ARRA are critical, says Dr. Ku, because they will help promote HIT among physicians, hospitals, and other providers that provide care for the poorest, most vulnerable patients. For certain types of providers, such as pediatricians, community health centers and safety net and children’s hospitals, this provides federal funding to secure and operate their electronic health record systems.

The biggest barrier to HIT that physicians typically cite is the cost of acquiring a system and training staff to use it. “This will help eliminate those barriers, but physicians’ offices will still need to provide the time to learn, understand, and use the new systems,” says Dr. Ku. If a provider

has already purchased a system, the incentives can be used for operational costs or upgrading.

“There are parallel provisions for

funding health care providers who care for Medicare patients, but they are somewhat less generous than the Medicaid provisions,” notes Dr. Ku.

“So, we’d expect that those eligible for both will select Medicaid funding.”

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Medicaid pilots aim to integrate physical, behavioral health

A doctor treating a patient with diabetes has no idea that his patient is also being treated for schizophrenia. Likewise, the patient’s psychiatrist doesn’t know he’s treating a diabetic. As a result, the care received by the patient is not optimal and could even be harmful.

With this all-too-common, uncoordinated scenario in mind, some state Medicaid programs are taking steps to integrate physical and behavioral health care. This has become a top priority of the “Rethinking Care Program” (RCP), a national initiative of the Hamilton, NJ-based Center for Health Care Strategies (CHCS) that is testing better approaches to care for Medicaid’s highest-need, highest-cost beneficiaries.

“Of the beneficiaries who have mental illness or a substance abuse disorder, many also have chronic physical problems such as cardiovascular disease or diabetes,” says **Allison Hamblin**, CHCS’ director of complex populations. “We are particularly concerned about the need for effective integration of physical and behavioral health care services in Medicaid, given the particularly high prevalence of these conditions among beneficiaries.”

One of the Medicaid health plans that CHCS works with recently analyzed its own claims data in multiple states. It found that the addition of one behavioral health condition—for example, a diagnosis of major depression—does three things. It doubles medical expenditures for physical health conditions, it doubles the ED visit rate, and it doubles the hospitalization rate.

“We think the data is representative of the landscape. There is no reason to think that it is any different anywhere else in Medicaid,” says Ms. Hamblin. “Across the gamut, the problem is of major magnitude.”

Interest is growing

Ms. Hamblin says that limited models exist today for coordinating physical and behavioral health. In many states, behavioral health is carved out from physical health management, and even when it is carved in, effective integration is not guaranteed.

“Irrespective of carve-outs and carve-ins,” says Ms. Hamblin, “there are very few places today where behavioral health and physical health coordination is going really well.”

Although a number of states are making an effort to work within their current system, Ms. Hamblin says “there are tremendous barriers out there, from a financial and systems delivery perspective, to effectively integrate care. However, we are hearing more and more interest in this issue from states. We have not seen any slowdown, despite states being overwhelmed with budget issues.”

Pennsylvania, says Ms. Hamblin, is a “great example of this. They still have not passed their state budget, but so far they have been successful in protecting their money toward their pilot programs to integrate physical and behavioral health services.” This is because integration of behavioral and physical health has become such a critical priority for states that it’s seen as a key to controlling the rate of growth of spending

for the state over time.

Although many states are struggling with this particular issue and have recognized the problems within their system, the problem is difficult to fix. According to Ms. Hamblin, “It’s safe to say there is no state that has fully figured out how to integrate physical health and behavioral health systemwide, although a growing number are piloting innovative approaches. Some are within the constraints of current systems, and others are in the context of broader reforms.”

System-level approach

Last year, CHCS surveyed about a dozen states to determine what they were doing to coordinate physical and behavioral health care. “From that effort, we got a fairly consistent sense that most states are moving toward some type of system, or at least thinking about their options, for how to organize and coordinate their systems of care for specific populations,” says Ms. Hamblin. “There is also a trend out there of moving away from fee-for-service behavioral health.”

Ms. Hamblin says the “gold standard is a system that truly integrates care for populations with physical and behavioral health needs.” One example of that is a system that aligns financial incentives and financial accountability.

“One of the many barriers to effective integration right now is that there is no alignment between payers and providers, given how the systems are operating and financed,” says Ms. Hamblin. “There is no shared accountability for outcomes.

States have become really good purchasers in so many ways, but contract requirements and performance standards in the area of physical health and behavioral health integration have not been sufficiently addressed to date.”

States really need to “up the ante in terms of what they are requiring from their contractors to support integrated care,” says Ms. Hamblin.

“Obviously ‘medical home’ is the buzzword out there. But we truly believe for complex populations with such a high prevalence of co-occurring conditions, these need to be accountable for both the behavioral and physical health sides of the equation,” says Ms. Hamblin.

In addition to aligned incentives and accountability, promising coordination approaches include information exchange across both systems and providers, use of a “navigator” to help coordinate care across systems, pharmacy management programs, and co-location strategies, among others.

Behavioral health first?

Efforts such as having behavioral health providers at large community clinics to treat depression more effectively in the primary care setting have been around for several years. While there still is a lot of interest in this type of effort, a small number of “early adopter” states are taking a system-level approach.

“They are scaling their efforts and going systemwide, with a particular focus on some of the more complex populations,” reports Ms. Hamblin. “A recognition is emerging that with the really complex subsets of the Medicaid population, behavioral health may be their primary need.”

Of New York State’s 25,000 disabled Medicaid beneficiaries with severe and persistent mental illness, 60% have at least one chronic med-

ical condition, and 29% have two or more. However, the health care costs of these individuals account for just 27% of their Medicaid expenditures, with the remaining 73% for behavioral services and pharmaceutical benefits, according to “Medicaid Managed Care for Persons with Severe Mental Illness: Challenges and Implications,” a 2007 report from the United Hospital Fund’s Medicaid Institute in New York City. Other states are finding similar numbers, as they analyze their own claims data.

“Given data like these,” says Ms. Hamblin, “there is growing recognition that integrated care is not nice to have, but rather, a *must* have.”

Incentives are aligned

One “early adopter” state is Pennsylvania, which is integrating physical and behavioral health services for adults with serious mental illness and physical health comorbidities with two regional Rethinking Care Program pilot projects. The pilots will each enroll up to 3,500 beneficiaries, and both will pair a physical health managed care organization (MCO) with a county behavioral health MCO.

Stefani Pashman, special assistant to the Secretary of Public Welfare, says CHCS approached the state in 2007 about the Rethinking Care initiative. In seeking to identify a population that presented a big opportunity for improving care and saving money, individuals with serious mental health and physical issues immediately came to mind.

“Both conditions can exacerbate the other, but we didn’t have good systems in place to deal with that. We have struggled a lot with this internally,” says Ms. Pashman. “When we started pulling data on patients, we realized that the lack of communication in many cases was making them even sicker. They were

deteriorating rather than being helped.”

The state holds a risk-based contract with a physical health MCO. For behavioral health, in most cases the state contracts with the county, which in turn contracts with the behavioral health plan. This approach makes integration “even more challenging,” says Ms. Pashman. “The state directly contracts with the physical health plan. For behavioral health services, the managed care contract runs through our counties, so we give each county the money and then the county subcontracts with the behavioral health plan. So, as you can imagine, that would make it a little tricky to coordinate.”

Despite this challenge, Ms. Pashman says her state’s Medicaid program “has a really robust benefits package. We do some of the best behavioral health managed care in the country, but we’ve never been great at getting all the people to talk to each other in a coordinated way. It’s always been sort of ad hoc. A case rises to the top, so people sit down and have a case conference with the behavioral health and physical health sides. But there was really no systematic approach for providers to share care information.”

Two pilots developed

Two pilots were developed, one in Allegheny County, which includes Pittsburgh, with UPMC Health Plan as the contractor for the physical health side, and Community Care Behavioral Health. The other pilot involves three counties, with Keystone Mercy Health Plan as the physical health contractor and Magellan as the behavioral health contractor. Both had a go-live date of July 2009 and will go through June 2011.

Both pilots have a “shared savings pool” with incentive funds put on

the table by the state, to be given out based on specific measures. For the first year, four process measures will be used, and outcomes measures will be added for the second year. The physical and behavioral health sides are jointly incentivized.

One-year evaluation

At the one-year mark, a decision will be made as to whether the physical and behavioral health partners earned their incentive payments for the first year payout. At that point, a broad analysis of overall costs will be done, to determine if ED visits and hospitalizations decreased as expected. At the end of

year two, a more comprehensive evaluation will be done, including interviews and case studies. "At that point, in addition to the data analysis done for the purposes of the payout, we will really get on the ground and look at every part of the project," says Ms. Pashman.

Expected outcomes include patients being stabilized on their medications, reduced hospitalizations, reduced use of the ER, and stronger relationships with the patient's medical home, whether a primary care practitioner, a psychiatrist, or psychologist.

"They are in this together. If they want the money, they have to work

together," says Ms. Pashman. "From what I understand, that is one of the more innovative pieces of this. This is the first time that physical health and behavioral health systems and the contractors are incentivized together with specific measures."

Ms. Pashman says ultimately, she wants to see strong relationships forged between the physical and behavioral health providers so that care coordination is "just second nature. It needs to be built into the system and happen with regularity."

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Medicaid programs get help in covering additional immigrant children

A growing number of states are providing health coverage to legal immigrant children and pregnant women through Medicaid or other state programs, under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Using the Immigrant Children's Health Improvement Act (ICHIA) option, states now have the option to provide federally matched Medicaid or CHIP to some or all of the legal immigrants they have been covering solely with state funds.

States getting federal dollars

For the most part, the states that are taking advantage of the ICHIA option had already covered legal immigrant children and pregnant women with state-only funds prior to CHIPRA, and therefore, "jumped at the opportunity to get federal dollars for this effort," says **Laura Parisi**, a health policy analyst with Families USA in Washington, DC.

"This basically allows them to keep covering these individuals for less money. It is good that we see that many states taking the option

to continue covering those folks, albeit with more federal help, as opposed to cutting the coverage altogether, which is obviously an option," says **Jennifer Sullivan**, a Families USA senior health policy analyst.

Fourteen states plus the District of Columbia fall into this category: California, Hawaii, Illinois, Massachusetts, Maine, Maryland, Minnesota, New Jersey, New Mexico, New York, Pennsylvania, Texas, Virginia, and Washington.

"Thanks to the ICHIA provision, Washington state is now covering lawfully documented immigrants under our Medicaid and SCHIP programs who were previously barred from this coverage under the five-year ban," says **Teresa Mosqueda**, director of advocacy and legislative relations at Children's Alliance in Seattle. Before ICHIA, these children were covered by Washington State children's health program for children who are income eligible, but do not qualify for the federally matched programs due to citizenship. "Now, we can offer the same health coverage to *all* children," says Ms. Mosqueda.

In addition, Delaware and Nebraska both currently cover legal immigrants using state-only funds, and are considered likely to elect the option. Connecticut also currently covers legal immigrant children and pregnant women using state-only dollars, but has not yet passed a state budget. The ICHIA option is proposed in both the governor's and legislative budget, and is considered very likely to pass.

"This will provide much needed federal reimbursement for a population we have been covering for years with state-only dollars," says **Sharon Langer**, JD, senior policy fellow at Connecticut Voices for Children in New Haven.

State proposes ICHIA coverage

The state's governor and legislature have proposed using the ICHIA option to continue coverage for kids and pregnant women. "Connecticut has covered recent immigrants since 1997, except for one year, with state-only dollars, says Ms. Langer. "Unfortunately, both the governor and the legislature have proposed dropping coverage for immigrant

adults living in the community. It is extremely unlikely lawmakers will find the state dollars to cover the adults.”

Utah, a state that did not previously fund coverage for legal immigrant children and pregnant women, acted early on electing the option and attempted to pass ICHIA legislation this past spring. However, this effort was defeated in the Senate.

In exploring the ICHIA option in CHIPRA, Utah estimated that an additional 800 children would have enrolled in Medicaid or CHIP. The cost to the state would have been \$391,600 for FY 2010. “CHIPRA was passed halfway through our state’s last legislative session, which runs from late January through early March,” says **Lincoln Nehring**, Medicaid policy director at the Utah Health Policy Project in Salt Lake City. “We had two legislators, a Republican in the House and Democrat in Senate, run legislation to remove the waiting period for children only. We have not been able to accurately estimate how many pregnant women would qualify, so it was decided to just do kids.”

Bills failed overall

Each bill passed its respective bodies. However, while support clearly existed in making this change, funding proved to be too great of a challenge. The Senate bill failed in the House, and the House bill never received a vote in the Senate. “We are running legislation again in the 2010 session to make the change,” says Mr. Nehring. “However, given the state’s budget situation and the increased money needed to cover the 20% enrollment growth our Medicaid program has experienced in the last year, chances of passage are slim.”

Wisconsin and Iowa, which both passed legislation to cover legal

immigrant children and pregnant women for the first time, did so as part of a larger eligibility expansion in their CHIP programs. The ICHIA option allowed Rhode Island to restore coverage for legal immigrant children and pregnant women, who were cut from the program in 2006.

“We are very pleased to say that Rhode Island has chosen to use the ICHIA provision in CHIPRA to restore coverage for lawfully residing immigrant children,” says **Jill K. Beckwith**, MPH, a policy analyst with Rhode Island KIDS COUNT in Providence. The governor submitted this as part of his recommended FY 2010 budget, and the General Assembly concurred, allowing Rhode Island to reinstate RIte Care coverage that was eliminated in June 2008.

Ms. Beckwith says CHIPRA allows Rhode Island to further build on the federal-state partnership to maximize all available dollars for children’s health coverage.

“Rhode Island has a strong track record of investing in children’s coverage,” says Ms. Beckwith. “The ICHIA provision enables leading states like Rhode Island to fully utilize all federal dollars on the table, and to build on and strengthen our commitment to making sure that all Rhode Island children have access to affordable health coverage.”

The Rhode Island Department of

Human Services (DHS) anticipates an approximate implementation date of Oct. 1, 2009, pending approval by CMS. The state estimates that approximately 1,272 lawfully residing immigrant children may enroll in RIte Care, which will enable them to get the checkups and preventive care they need to stay healthy and see the doctor when they get sick.

Colorado passed a bill in the last legislative session that authorizes ICHIA when funding becomes available. Although funding is not currently available, the authorizing language allows the Department of Health Care Policy and financing to submit a budget request in a future fiscal year that allows for providing Medicaid and CHIP to legal immigrant children and pregnant women.

“This is a very positive step in the right direction for Colorado,” says **Adela Flores-Brennan**, health care attorney with the Colorado Center on Law and Policy in Denver. “The five-year waiting period is such an arbitrary concept that creates health inequities and disparities for a population of Colorado’s pregnant women and children who, but for the five-year period, would be eligible to receive affordable health coverage.”

Ms. Flores-Brennan says it is poor policy to exclude them. “The impact on the state budget will not

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be huge, relative to other Medicaid costs or other populations,” she says.

The fiscal note that accompanied the bill anticipated implementation in fiscal year 2010-2011. “It remains to be seen, though, whether it will be part of the governor’s budget request,” says Ms. Flores-Brennan. “While, of course, it is disappointing that we have to wait for funding, it is the fiscal reality for us and most other states.”

For 2011-2012, the state anticipates being able to cover 1,316 pregnant women and children in Medicaid and the state’s CHIP program (CHP+). In 2012-13, the forecast increases to 2,626.

“Colorado previously covered, using state dollars, only pregnant women who were made ineligible for Medicaid by the five-year waiting period,” says Ms. Flores-Brennan. “The passage of ICHIA here allows us to draw down federal matching dollars for those women and expand to cover legal immigrant children in Medicaid and CHP+, and legal immigrant pregnant women eligible for CHP+.”

Numbers aren’t large

In actuality, the number of people actually covered with the ICHIA option is not that large. “The biggest burden is the ideologic one, as to whether or not you should be providing coverage to immigrants,” says Ms. Sullivan. “Some states are in a tight situation, and they may make the budget argument. But at the end of the day, we are not talking about adding a significant number of children to the rolls. There aren’t many children that fall in this five-year bar category.”

What ICHIA does is simplify the program. “And obviously, the CHIP match is very favorable. So, states are getting a lot of money to provide coverage to immigrants,” says Ms. Sullivan.

There has not yet been any official guidance from the Centers for Medicare & Medicaid Services on ICHIA. Some states may be adopting a “wait-and-see” approach before moving forward.

“It seems that states are still very committed to getting kids covered, even more so that the recession is affecting more and more families.”

**— Jennifer Sullivan
Families USA senior health policy analyst**

“I’m not sure we will see a huge flood of states wanting to pick up the option once that guidance is out there,” says Ms. Sullivan. “But I would bet that some states are going to be a little more hesitant to plow down that path until they see what the official matching rate is going to be for the various populations. This is particularly true for states that want to do this for the first time, and are going to be putting up some of their own dollars for this that they weren’t putting up before.”

Generally speaking, there have been a lot of gains made in children’s coverage this year, despite the recession. “It seems that states are still very committed to getting kids covered, even more so that the recession is affecting more and more families,” says Ms. Sullivan. “If a family loses a job and was never eligible for this kind of coverage before, they are the poster child for what CHIP is designed for. So, states are recognizing that, and to the extent that they can, they are keeping their doors open.”

In some cases, there has been fairly large eligibility expansion, and

also simplification of the application process. “Part of the reason for that is states are reaching for what CHIPRA calls performance bonuses. This is extra money for states reaching out to get kids enrolled,” says Ms. Sullivan.

Some states are making a single application for Medicaid and CHIP, or doing express lane eligibility, so families can get other coverage as well if they need it. “Those are no small things when it comes down to it,” says Ms. Sullivan. “You can have a great program, but if no one knows about it or can get in the door, then it’s not helping anyone.”

One big exception is California. “With almost a million kids enrolled in that state, coverage is really in jeopardy right now. This is a travesty and something we are watching very closely,” says Ms. Sullivan.

Other states have contemplated either capping their programs or scaling back some expansions. But for the most part, states are eager to continue the mission of getting kids covered. “And I’m not entirely surprised,” says Ms. Sullivan. “CHIP is a popular program. States like it because they get a lot of bang for their buck. And we just went through a long, tedious, two-year struggle to reauthorize the program.”

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Out-of-pocket expenses for prescriptions surprisingly high

At the Rockville, MD-based Agency for Healthcare Research and Quality's (AHRQ) 2008 annual conference, Jessica S. Banthin, PhD, director of AHRQ's division of modeling and simulation in the center for financing, access and cost trends, was one of the presenters of a paper on "Prescription Drug Expenditures and Healthcare Burdens in the Medicaid Population." Dr. Banthin says this research still is a work in progress.

"We have redone the analyses in order to focus particularly on a trend we've identified," says Dr. Banthin. This involves the Medical Expenditure Panel Survey data, which show high out-of-pocket expenditures for prescription drugs even among families where everyone is covered by Medicaid.

The researchers focused on data from 2004 and 2005 for a subset of

families where every person is covered for the full year by Medicaid. This accounts for about one-quarter of the nonelderly Medicaid population. "We did this to make the analysis as precise as possible," says Dr. Banthin.

The researchers found that about 14% of this group has high out-of-pocket burdens for health care. This means they spend more than 5% of their family income on out-of-pocket costs for health care services, totaling about \$900 per family per year.

"About two-thirds of families who meet our definition of 'high burden' are in this category because of prescription drug expenditures," says Dr. Banthin. "Since every member of the family has Medicaid, it is surprising that they are spending so much out of pocket on prescription drugs. Copays for Medicaid enrollees are supposed to be nominal, about \$3 to \$5 per prescription or refill."

Dr. Banthin says that the research team is continuing to explore these findings. Preliminary evidence suggests that some of the spending derives from copayments. However, a large portion also derives from prescriptions where the Medicaid enrollee has paid the full retail pharmacy price and has not bothered to use or apply his or her Medicaid benefits.

"We do not yet know whether this is because of Medicaid rules that require prior authorization, step therapy, or place limits on the number of fills per month," says Dr. Banthin.

Contact Dr. Banthin at (301) 427-1678 or Jessica.Banthin@ahrq.hhs.gov. ■

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